MDR: M4-02-2664-01

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-03-1628.M4

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $7,675.70 per conversation on 08/02/02 at 11:00am with provider representative, for dates of service 06/26/01 through 06/30/01.

   b. The request was received on 02/28/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 05/20/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 05/21/02. The response from the insurance carrier was received in the Division on 05/30/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   The only response from the Requestor is from the Table of Disputed Services, which states: "Claim should have been paid at 75% as bill exceeds 40K."

2. Respondent:

"This letter is in response to the medical dispute resolution requested by (Provider). The dispute centers on a bill, which exceeded the stop-loss limit of $40,000. Here is why (Carrier) does not believe (Provider) is entitled to any further payment. (In fact we have requested a refund from them and may pursue a medical dispute resolution of our own.)

1. The bill only exceeded the stop-loss limit because (Provider) billed an overly generous mark-up on the implants. They billed $34,030.00 for the implantables. The invoice indicated the cost of the implants was $15,208.00. When we add 10% to this, we get a total of $16,728.80, which is what (Carrier) paid.

2. (Carrier) contacted the Medical Review Division about this issue, because we had several inquiries about it. I am enclosing an e-mail reply, dated 2-8-02, from (TWCC employee) in your division instructing us that we needed to pay the bill at stop-loss rates regardless of the mark-up on the implantables. Based on (TWCC employee) reply, a supplemental payment of $6,041.41 was issued to (Provider) on 3-5-02. Here is how we arrived at this figure:

Total charges:	$46,557.21
Less Implants	-$34,030.00
	12,527.21
Less initial Payment	-$4,472.00
	$8,055.21
	X .75
Supplemental Payment Amt. =	$6,041.41

3. Shortly after the supplemental payment was made, I was reviewing SOAH rulings and found where an Administrative Law Judge (ALJ) ruled on a situation comparable to this dispute. According to the ALJ, a carrier should be allowed to reduce charges for implantables to cost plus 10% to calculate whether a bill exceeds the stop-loss threshold. I am enclosing a copy of the ruling, for your reference."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 06/26/01 and extending through 06/30/01.

2. The Provider billed the Carrier $46,557.21 for the dates of service 06/26/01 and extending through 06/30/01.

3. The Carrier made a total reimbursement of $27,242.21 for the dates of service 06/26/01 and extending through 06/30/01.

4. The amount left in dispute is $7,675.70.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $46,557.21. Per Rule 134.401 (c)(6) (A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), those not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. Per the EOB, the Carrier deducted $10,547.21, but it is not possible to tell for what. The Carrier denied "Hospital Services" as G-Global. The Carrier also reduced the implantables. Per the information submitted by the carrier and the provider, an invoice was submitted with the per/unit cost of the implantables. In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, which is indicated in the Medical Fee Guideline since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the Hospital. Even if the charge appears to be inflated based on the invoice or based on information from the Fee Guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the Hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

The hospital has billed its "usual and customary charge" of $34,030.00 for the implantables. The carrier has not submitted evidence of what is usual and customary in that region for these items.

Therefore, the total reimbursement will be calculated in the following manner:

Total charges are $46,557.21.
Multiply the audited charges of $46,557.21 x 75%
$46,557.21 x .75= $34,917.91
The carrier paid $27,242.21
$34,917.91 - $27,242.21 = $7,675.70
Therefore, additional reimbursement is recommended in the amount of $7,675.70.

The above Findings and Decision are hereby issued this 14th day of August 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $7,675.70 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 14th day of August 2002.

Carolyn Ollar R.N., B.A.
Medical Dispute Resolution Officer

Medical Review Division

CO/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.